Modern Medicine and its — Military Links —

Part 2 of the Dr Alan Levin interview, revealing intriguing links between medicine and the military-industrial complex.

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*[**Editor's note:** Claire W. Gilbert, Ph.D., Publisher of* Blazing Tattles *newsletter, conducted this interview with Alan S. Levin, M.D., immunologist, brave medico and self-declared "quack". Dr Levin provides a rare insider's view and courageously speaks 'on the record'. This interview is a unique document, clarifying some of the past few decades' little-known and little-understood bouts of military and medical madness.]*

DOUBLE-BLIND STUDIES ARE UNSCIENTIFIC

Levin [L]: About that same period of time we lost Kennedy, well prior to that, we had this 'thalidomide scare', and with the thalidomide scare, the mandate of the Food and Drug Administration (FDA) expanded dramatically. So all of a sudden we had a law where you had to prove the 'efficacy'—you had to prove your drug worked—so instead of simply identifying 'toxicity', you had to identify efficacy.

In order to identify efficacy, you had to do some strange, so-called 'scientific' studies. They are not very scientific. The double-blind, placebo-controlled studies are totally unscientific! I'll go into that later. I am a scientist.

Gilbert [G]: I am, too. Doctors swear by that (the double-blind studies).

L: Doctors are not very well trained in science. That's the problem.

G: Research, scientific logic and all that. I agree.

L: Basically, then, the mandate for bringing drugs to market became totally unrealistic. So the average drug that may have cost a million dollars to go to market in 1963 now would cost $200 million to go to market, and much of the money goes to investigators, patent attorneys and clerks.

G: Because they need to prove that 'it works'.

L: Right. So you have this strange situation where you have this non-scientific way of proving a drug—this double-blind, placebo control—which means *nothing*.

Whether a drug makes it to market simply means that someone has had enough money to put it through and pay the right politicians. That's all. It doesn't mean it works or it doesn't work. And you can think of the FDA as you do the Post Office. It's the same mentality, the same level of competence. So, basically, we have this very strange situation and, in addition to that, we have the concept of capitation grants.

Now, what happened was that the Government thought doctors were too busy as small business people, you know, worrying about income tax, rent, personnel management and all that, and that if they took these people and put them into the universities, and took all these responsibilities away, then these physicians would be totally dedicated to teaching and research, and be more effective. And that sounded great!

Prior to that, the full-time academic was considered to be a nerd. The old saying was: "If you can't do it, teach it." When I was in medical school, we used to wait for the 'real' doctors to come in and teach us real medicine, because the guys in medical school had never seen patients and they didn't know anything. But then, after that, the drug companies kind of took over and they started funding these full-time academics.

So basically you've got this nefarious tie between the drug companies, who are trying to prove something that couldn't be proved, and the academics, who really had no responsibility for patients. The average full-time academic today—physician, professor of medicine—has at least four people between him and the patient. You have the fellow, the resident, the medical student, and the intern, and then you have this entire institution protecting him. So the average academic physician really is not prepared to handle sick people.

G: I want to backtrack a second. What's your critique of the double-blind experiment?

L: First of all it was designed by people, both of whom are friends of mine. One continues to be a very close friend of mine. The first one, Joe Nehman died, and my wife was

his doctor. The other one, Bush LeCam, is a very close friend. My wife shares a birthday with him, and his daughter is a patient. We're very close.

So we're very familiar with the people who developed the double-blind, placebo-controlled study. And we know what they know about medicine and science, and they all admit that they don't know anything about it.

The problem with the placebo-controlled, double-blind study is that you are using two human beings as controls against one another. There is no species more outbred on Earth than two human beings. A person from the North Pole can procreate with a person from the South Pole, and can have an infant. There is no animal on Earth that is as out-bred as human beings, including two identical twins. They are not the same because as soon as the zygote divides there are different positions, there are different antigens to which they are exposed.

G: But in the experiments they are not done on just two people.

L: Let me go on. Two human beings are different from one another. That's the first problem.

The other problem is the problem of diagnosis. Diagnosis is simply a pigeon-hole into which a doctor places a patient. So Mr A has 'A's Disease' and Mr B has 'B's Disease', and they share some symptoms and lab tests so we call them 'diabetic'. But they don't have the same disease, they are not going to respond to the same treatment course, and they are not going to respond to the same doses.

So if I took 100 people that the competent physician would diagnose as 'diabetic' today and followed them for ten years, some of them will have eye disease, some of them will have heart disease, some of them will have kidney disease, and some of them will have gangrene of the big toe. Some guy ten years from now will say: "How could this stupid guy make this diagnosis of 'diabetes' on Mr Jones who had gangrene of the big toe, and Mr Smith who has eye disease?"

"Whether a drug makes it to market simply means that someone has had enough money to put it through and pay the right politicians. That's all. It doesn't mean it works or it doesn't work."

The bottom line is that this is simply a pigeon-hole into which to place a patient to give you helpful guidelines for treatment, but it is not hard and fast. It is not locked in granite. What you've got is that you are trying to make a diagnosis; and you make a diagnosis of diabetes on two different people who are two different animals with two different diseases, and then you are studying the effects of this. So you need large numbers, and you need *statistical significance*, so basically what you do is you expand the numbers.

Well, a double-blind, placebo-controlled study may make sense if you had 100,000 people in each arm, but you don't. Usually you have about 30 or 40 or 50, or maybe 1,000 on each arm, even then it's not enough. But when you do this you get into a situation that if you get five people who are absolutely cured and 95 who go on and have the same disease process, you probably have a cure for five people, and that's a subset of the disease that is cured by 'Drug X'.

But if you went to the double-blind, placebo-controlled study, it would probably wash out because it is not statistically significant. (Publisher's note: This means that the 'double-blind' study ignores a significant amount of information which could help certain people.)

Now what is the alternative? How do you do these studies so you know what's going on? You use the patient as their own control. (Publisher's note: This means you compare the patient's health before and after the use of medication, rather than comparing the average result of an experimental group of people who get the medication against the average of those who don't get the treatment.)

You follow biochemical parameters of progression and regression of the disease. For example, if you did a double-blind, placebo-controlled study of insulin in diabetes and used that as an influence, that would be what the average physician does today.

On the other hand, if you measured blood glucose you could get more information without the suffering.

The difficulty is that the physician has to understand blood glucose. It's that simple. That's what we're dealing with today.

The average so-called 'medical scientist' really doesn't know science. When you get to the situation where you are trying to study the efficacy of AIDS drugs—and I got into this situation—I was measuring different parameters, B- and T-cells, T-4s, T-8s, Beta-2 marker globulin, P-24, sed (sedimentation) rates, all sorts of biochemical parameters, and I was adjusting treatments according to these biochemical parameters. The problem was that I got a lot of flack. Why? Because these people were doing their double-blind, placebo-controlled studies using death as an end-point.

But I said: "Well, why don't you use these biochemical parameters?" And they screamed and hollered, and then they called them "surrogate markers", and I said: "Well, fine. So now you are following surrogate markers." Well, 'respiration' is a surrogate marker for 'life'. 'Pulse' is a surrogate marker for 'living'. Right? I mean, bullshit they are surrogate markers!

These are what real doctors use (biochemical parameters). This is what science is. This is how you treat patients. You don't wait for them to die.

Well, why do you (academics) call them "surrogate markers"? Because you don't understand what they are. You aren't well enough trained in science to understand what a P-24 antigen is, and what it means. You are not well enough trained to know what a T-4 cell is. But you're a 'professor of medicine' at UC San Francisco, and you are supposed to be an expert on AIDS and you 'pooh-pooh' it (biochemical parameters). It doesn't mean anything, right?

The bottom line is that these double-blind, placebo-controlled studies are run by people who don't know much about science.

Let me give you another very classic one. It's done by this guy, Frederick Stare, who was a professor. (Publisher: At Harvard, I believe.)

G: Oh, I know, the 'nutrition doctor' who said vitamins are no good?

L: Right.

G: He said: "Chocolate-chip cookies are good (for you)?"

L: Chocolate-chip cookies. Sugar is good for you.

G: He's a scandal.

L: But he's a classic.

G: Right. But everyone cites him, right?

L: Oh yeah, yeah. But that's the bottom line. That's what it's all about. So these are the kind of people you get, and they are being used by the drug companies because—who cares? It's the same kind of thing. "I don't care if the thing works; I just want to make money on it." So that's what's happened.

Basically, we have the situation where we have the full-time

academics and we have the drug companies with their ridiculous mandate from the FDA; and so they marry one another and we have what we have today, which is this bizarre situation in which medicine is run by these people who really are not very good at science.

I'll give you an example. This is *The New England Journal of Medicine*, okay?

G: I thought that that was one of the better ones, too, I mean more liberal.

L: Really? Eighty-three per cent of its revenue comes from drug advertising. What do you think this costs? Eighty-three per cent of its revenue comes from drug advertising.

In addition to that, the very highly touted drug called Mevacore, lovastatin, is a drug that lowers cholesterol. Now, this is my opinion: The purpose of Mevacore is to allow 'Joe Six-Packs' to eat his 'Twinkies' and 'Ding-Dongs' and not worry about his cholesterol. You are not going to get very much about diet control in this journal because Mevacore doesn't want it. You know, Merck, Sharp and Dohme doesn't like diet control because obviously diet control cuts their profits. So, this is simply a trade journal. That's what it's all about. It's a nice one. I like it. But it's not a credible journal. It's not really good science, but it's fun to read. Kind of like *National Enquirer*.

"...in the State of California, as late as five years ago, it was illegal to say bad things about pesticides and herbicides. You could get your licence taken away."

G: So the people who make money off the Military are now getting into the drug business? This is an area in which they can make bucks, right?

THE TIE

L: So let's do the tie. We are going back again to the military-industrial complex and their involvement in medicine. What happened, in my opinion at least, is that they are looking for another market because war is not quite that profitable any more, so they're going into medicine, and they have found themselves an ally in the academic physician who really doesn't know much science, who really doesn't care much about patients, but who has car payments and, you know, who wants to feed his or her ego and so they want to publish in everything.

G: Build a little 'empire'?

L: Yeah, right. So basically, what have we got today? We've got Lockheed who owns Dialog database. McDonnell Douglas runs 70 per cent of the hardware and software of all the hospitals in the country. Hughes Industries runs the largest research programmes as we talked about, at Hopkins, Harvard and UC San Francisco. Their budget for so-called medical research is greater than the Federal Government's in the year 2000! FMC works with Hypertech on mononuclear antibodies. Colt Industries works on urinalysis. General Dynamics, General Motors, General Electric, Delco—they're all into medicine and into defence. Now, that's the bad news. Now let me tell you the good news.

The good news is that when I went around hollering that the M-16 rifle was bad, or that the CH-46 helicopter was bad, or the A-21E helicopter was bad, or the F-14 was bad, nobody really cared. They laughed about it. And it's a joke that the military equipment doesn't work. Everyone joked about the so-called 'smart bombs' that weren't very smart, or the stealth bomber. You know the pictures, that everything is just sort of photographs so that you look at these war toys and everybody talks about them, but they don't really care that the kid that's running it, an eighteen-year-old boy, is going to get killed. That's not important, because eighteen-year-old boys in the United States are not important. You can feed 'em drugs, you can feed 'em pizza, send them to the Military and have them go crush 8,000 Arab boys—then hang a medal on 'em, give 'em a flag-draped coffin and you're in fine shape. And that's The American Way; that's how they feel about boys.

But the cannon-fodder in this war is 'Joe Six-Packs'—the consuming public and Joe Six-Packs. You can fry his kid, he doesn't give a damn, but don't get into my genitals, or my hairline or my breasts, you know. That's the problem.

G: For the first time, I'm having trouble following you.

L: Well, what I'm saying is that average American adult is more driven by his or her hairline, how hard his penis is or whether her breasts are soft, than they are about the well-being of their son. So, basically, I used to run around the country and say that trichlorethylene causes birth defects and learning disabilities and childhood leukaemia; and everybody said: "Well, that's irresponsible. We need more studies and more epidemiology."

G: Well, what is that?

L: It's degreaser in the water. It's very common.

G: In drinking water?

L: Yeah, yeah. Then, I used to run around the country saying the same chemical causes wrinkles and impotence and soft breasts, and snap!—it's illegal!

The bottom line—and so now we are getting to Joe Six-Packs—and, like I say, the M-16 rifle doesn't work and the F-14 doesn't fly, and they even make a goddamned movie about it and nobody gives a damn.

You know, *Top Gun* was all about the fact that the F-14 didn't work, and yet nobody even picked it up. I mean, the goddamned machine doesn't work in combat, but that wasn't what people saw. They saw this 'honcho' kid running around.

But they do know that if they can't get it up that night, maybe it's the trichloroethylene in the water—and I'm getting to them, and that's one of the reasons that the chemical companies hate my guts.

G: I'm surprised they let you live!

L: They can't do me in.

G: No?

L: No. Yes, they can. The only people who could do it are people who are friends, and it can happen.

G: You have protection?

L: Yes, ma'am.

G: Like Joe?

L: Yes, ma'am. It's not Joe. It's not Joe at all. It's professionals. Government-paid professionals.

G: They're your friends?

L: You'd better believe it. I gotta tell you, these guys are *very* honourable and they have the same goals that I have. They are good people. They just play hard ball.

G: That goes over my head, too.

L: That you don't have to know.

So right now, I'm hated more than Ralph Nader was hated at his peak because I'm getting to Joe Six-Packs. And of course Bill Rea and I vie for who's "No. 1 Quack" in the country. I've been written up in *Forbes Magazine* and *Galileo's Revenge*. The latter was used by Dan Quayle in his attack. It's part of the *Tort Reform Act*. They talk about "junk science" in the courtroom, and I'm the "junk scientist". It's a very widely used book by the chemical companies. The author's name is Peter Huber.

G: So how did you get into environmental medicine (clinical ecology)?

L: Through Phyllis Saifer.

Basically, then, after kind of running amuck with the university and all of the politics, I went into the practice of pathology. I still stayed at the university and my wife is still at the university, but I went into the private practice of pathology. I'm a pathologist.

I was running the first immunology lab in the area in the late 1970s, and this colleague of mine, Phyllis Saifer, whom I thought was a "quack"—a delightful quack, but a quack—used to run around talking about these people who had strange reactions to perfumes and cigarette smoke and all that kind of stuff. So I kinda shined around because she was a real nice lady, and I said, "Why don't you measure T-cells?"

I don't know why I said that. I am the first person upon whom T-cells were ever tested. I'm in the first paper ever describing T-cells, so I am very familiar with T-cells. And at the time I thought I knew all there was to know about T-cells, and at that time I was an arrogant academic anyway.

So then one day my tech came into the office and said: "There is something wrong with our assay because the controls are fine, but patients are all low." So I went in and looked, and they were all Phyllis' patients! And so then I began to interview the patients and they all had the same strange symptoms.

To make a long story short, it made logical, perfect sense. What was going on was that toxic chemicals were damaging their immune systems and they were developing autoimmune disease. It was perfectly logical.

In the meantime, being a lousy businessman, busting my own lab, I decided to go into private practice, and since she had such an interesting patient population—and since her office was closer than my other friend's, who is a traditional allergist, and I loved them both, but she was closer—I decided to go to her office to learn how to practise medicine. And so I worked with her and she taught me how to run a practice. You know, worker's comp and all that business.

"There are even *bounties* now being given by drug companies to go after doctors who treat nutrition."

At that point she told me about a controversy between the clinical ecologists and the ordinary allergists, and I couldn't believe it! I couldn't really believe that the allergists were going to say something about what clinical ecologists did, because as far as I knew, it was kinda like a left-handed surgeon and a right-handed surgeon arguing about how to take out a gall bladder. And it didn't make sense. In the beginning, I didn't believe it.

But then I began to see, indeed, there was this controversy, and I began to question what it was. And they started talking about it's the allergists who are worried that the clinical ecologists are going to take their revenues away. I said, "No, that's not it. It's not that at all. Doctors aren't smart enough to do that. There's something more there."

Then I began to look a little closer, and I began to say: "Gosh, you guys are talking about food allergies, and you're talking about allergies to chemicals. What does the food industry and the chemical industry have to do with this so-called 'battle'?"

I began to look, and lo and behold! There it was: funds, *directly* given to the academic allergists to attack us, from the drug companies and the nutrition companies.

G: Really? This wouldn't be a research contract, this would be like perks?

L: Right. There are even *bounties* now being given by drug companies to go after doctors who treat nutrition.

G: Some doctors in New York have lost their licences.

L: I know. I'm involved with a lot of those things. Anyway, so people are given bounties to turn these people (doctors) in.

G: You mean, like a patient will go and turn them in.

L: Yes. Or a doctor will be given 'x' thousands of dollars in order to turn in a doctor. Yes. And this is well-documented.

G: And this is being done to protect the food industry and the chemical and drug industry?

L: Yes. I can go on that in the State of California, as late as five years ago, it was illegal to say bad things about pesticides and herbicides. You could get your licence taken away. You could make love to your patients (unethical), you could do drugs intravenously (illegal), you could sell drugs out of your office, and

you'd be okay. But if you treat with nutrition or preventive medicine, you're risking your licence.

I could go to any hospital in this state, because I'm qualified in cancer, and give 5-Fluorouracil to a colon cancer and kill them. I can show you now twenty articles that prove that 5-Fluorouracil doesn't work in colon cancer. If I used this same patient and hung a bottle of intravenous vitamin C on that same patient, I risk losing my licence, even today. Why?

It's the companies. It's the chemical companies. It's the drug companies. That's what it's all about. So it's pretty clear that this particular controversy between clinical ecologists and conventional allergists has nothing to do with the science of medicine. It has to do with economics.

G: I didn't realise on what scale.

L: Oh, it's enormous!

G: As a sociologist, I just thought it had more to do with the stuff you learn which becomes your 'reality', and this is a *threat* to reality when these other people are doing something else. I thought it was on that level that the problem existed. I didn't realise that it was much more, you know, organised.

What I don't understand—what I wanted to ask you, if you can explain it to me—is that people like to think of themselves as good people, okay; so how do these doctors who are bought off, maintain their self-image as good when they are harming patients? Isn't there some self-deception involved?

L: Um-huh.

G: Like, they feel they believe that anyway, so it's okay to take the money?

L: To some extent, yeah. Everybody's got car payments. That's what it's all about. And, yeah, they'll lie and cheat and steal and testify. The Nazis testified. And I don't know that the Nazis were all bad. Hughes is no better than Hitler was.

G: How's that?

L: I described to you what was going on. The major difference between Hitler and Hughes was that Hitler went after Jews. Laotians and Cambodians didn't scream quite as loud as the Jews did.

G: Well, they talk another language.

L: And they looked different. The difference between the Arab government and the American government is the Arabs sacrifice 14-year-old boys for greedy politicians and the Americans sacrifice 18-year-old boys for the same reason, so I guess the Americans are a little more honourable. Who knows? Yeah, let's face it. The bottom line is that these people are scoundrels, but they justify themselves. Carnegie was classically a scoundrel and so was Rockefeller, but they put a lot of money into that. What do you think that Nobel did? He made dynamite to blow people up. And we have the Nobel Prize. I mean, give me a break. People are proud of having a Nobel Prize. What for? They made the money from blowing up women and children. If you didn't know that, it's because you didn't want to know.

> **"The same thing that these Gulf War people got. It does have a name: Chemically-Induced Immune Dysregulation."**

DESERT STORM SYNDROME HAS A NAME

G: Now, some of the Gulf War vets have come down with ailments.

L: Yes.

G: And a lot of doctors say, "Well, this is just stress."

L: Right. They have to, in order to keep their licences.

G: Others say, "Well they had this oil smeared all over them. They were breathing the fumes.

L: Ha! What do you think?

G: Who was the one who interviewed Dr Rea before they got sick? And who published "Can oil-fire smoke affect your health?" in *Blazing Tattles*? (Me, me, me!)

L: Right!

G: It affected my health—I was living in Florida and I had to wear a mask some days to go out.

L: Right.

G: Because I am extremely sensitive.

L: Do you remember we used to use X-ray fluoroscopy to see if our shoes fitted. If you talk to a ten-year-old boy today, he would say: "God, I can't believe people would be that stupid. It's gotta be a lie." And if we are successful, ten years from now I'm gonna tell a ten-year-old boy that we used to spray pesticides from airplanes and this boy will say: "God, that's stupid, those are poisons. You wouldn't do that!"

G: I lived in Florida years ago and they sprayed right over my house!

L: There are several reasons for the problems we have. One is the inertia of the average medical community, which is legitimate. Physicians should be conservative, but the problem is here that there are special-interest groups which are funding the maintenance of the status quo. These are the manufacturers of Mevacore, Inderol, steroids and all that.

G: So it's the food industry and the drug industry, and now you have your defence contractors.

L: It's exactly the same mentality and ethics as when they ran the wars. They burned the Reichstag, they sank the Maine, Pearl Harbour was a 'sneak' attack, the Gulf of Tonkin incident was a nefarious thing. It's the same bullshit all over again. Same thing. But the difference, I say, is that we now have a foothold because the cannon-fodder is a 'real American'. It's not a 17-year-old boy: it's a guy who can buy a politician, who can invest in a political action committee, who can buy an attorney.

I mean, real Americans—people who hold mortgages, and pay taxes, real Americans—are being poisoned. They are dying of cancer.

G: How are they making the connection? I mean when I was a kid, cancer was 'an act of God'. Like my father's uncle died of cancer when I was four years old. In those days, it was an act of God. But today, most cancers are environmentally produced.

L: Right. Right.

G: So how does the adult American know this now? Because there's so much stuff in the mass media?

L: One of the reasons is that our lawsuits are high profile. In fact, I've got to tell you honestly that I got involved with the clinical ecologists for this very reason, so we could get Joe Six-Packs involved. Unfortunately, I made a lot of trouble for the clinical ecologists because they were considered to be a sweet little group of nothings until I started moving them, and then they are really just considered the pariah.

There's an attorney who is the chief counsel for Monsanto, and after the District Court's decision on *Sterling vs Velsicol*, the Chemical Manufacturers Association had an emergency meeting. This same attorney at that time was the chairman of the committee, and he's quoted as having said that if people believe Levin's

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theories, he can singlehandedly bankrupt Corporate America. This was like 1981 or 1982. It turned into a big, big thing.

Like I say, it's the chemical companies, drug companies and all that. And it's really kind of funny because these people are chasing their tail. For example, among the people in Dow Chemical Company who claim that Bill Rea is a "quack", many of them go to him. You know, board chairmen go to him because they're sick. They know it's true, but it's not good for business. We're gonna make it good for business.

I mean, basically we don't want to shut the chemical companies down. We want people to be less cavalier about the use of these chemicals.

For instance, when we used to use X-ray fluoroscopy to see if our shoes fitted, we used much less X-ray than we do today, but we were just a lot more cavalier about it. And that's what I want, and that's what we all want with chemicals. We don't want to shut the plants down or stop using them or anything—we just want to be less cavalier.

And if you look at the way computer chips were made five years ago (they are changing now), the way they were manufactured in the United States and in Japan was really striking. They were doing exactly the same process with exactly the same chemicals. In Japan, people were wearing masks and respirators and working behind hoods and wearing protective clothing. In the United States, people were dipping things in and out and smoking and eating lunch.

G: And they were getting this 'disease that has no name'. I read about that.

L: Right. The same thing that these Gulf War people got. It does have a name: Chemically-Induced Immune Dysregulation.

Let me show you what immune dysregulation in my opinion is. This is kinda my favourite thing. Let me just finish up with this. We'll start off here.

G: The blind men? I did my doctoral thesis on that.

L: Oh, good. Before the turn of the century there was a group of scientists and physicians who were injecting bugs into rabbits. And the injections exempted the animals from the cost of disease.

G: Oh, vaccination.

L: Yes. So they called themselves immunologists, and about the same time there were people studying endocrinology, neurology and psychiatry. After the turn of the century, people began studying hay fever, and they were allergists. These were all separate disciplines until the 1920s when neurology and psychiatry got together because they were the same discipline. And in 1967, allergy and immunology got together for the same reason.

In the late '70s and '80s, everybody got together. They're all studying biological response modification, and are all looking at the same system. And this system really isn't an immune system. We were not endowed with it to protect ourselves with hazards from the environment: we were endowed with it to control growth and differentiation of virtually every organ from the mesodermal layer of the embryo. And so I, as an immunologist, am looking at only one component, but this is 'chemically-induced disorders of biological response'. And that is what this disease is. That it has no name is bullshit!

G: So lawsuits are the vehicle by which the adult Americans are beginning to realise that these things are affecting their

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beauty and health.

L: I have never seen a vehicle of social change that works as fast and effectively as the toxic tort arena. Never. And the toxic chemical lawsuits have done more for humanity than anything else. And the bigger the settlement, the better it is.

And let me tell you this: we are wearing safety belts not because someone published in *The New England Journal of Medicine*, but because somebody kicked somebody's tail in a lawsuit. That's the only way to get people to turn around: you have to hit 'em where they live, you have to cost them money. So these lawsuits are wonderful things, and the more money that is generated from them, the better it is for humanity.

G: It costs the industry money, or whoever is being sued, but on the other hand, as you said before, it sounds like the benefit is that it makes people aware.

L: Right. Right. It makes them aware of what is going on. These lawsuits are incredibly beneficial. And if you had tort reform you would really cause a lot of problems, because then there would be very little way you could get at people who are doing very nasty things.

G: Is that why there has been a movement underway to control the amount of money people can get in lawsuits?

L: Yes, oh, yes.

G: It isn't just to protect the insurance companies.

L: No. Not at all. Basically, it's to allow people to maintain the status quo.

G: Do you want to say anything about the way you treat people whose immune systems are damaged?

(Time ran out here. I was handed a published article to answer this question: Alan S. Levin, M.D., and Vera S. Byers, M.D., Ph.D., "Multiple Chemical Sensitivities: A Practicing Clinician's Point of View, Clinical and Immunologic Research Findings", in *Toxicology and Industrial Health*, vol. 8, no. 4, 1992, pp 95-109. It will be summarised in a forthcoming issue of *Blazing Tattles*.) ∞

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